Physician Quality Reporting Initiative
Measures Groups Specifications Manual

This manual contains specific guidance for reporting 2009 Physician Quality Reporting Initiative (PQRI) Measures Groups. Seven (7) measures groups have been established for 2009 PQRI: Diabetes Mellitus, Chronic Kidney Disease (CKD), Preventive Care, Coronary Artery Bypass Graft (CABG), Rheumatoid Arthritis, Perioperative Care, and Back Pain. These seven groups, combined, include a total of 44 measures established for use in the 2009 PQRI, as required by applicable statutes, through formal notice-and-comment rulemaking in 2008. The measures groups may be reported through claims-based or registry-based submission.

The 2009 PQRI Measures Groups reporting alternative is available for the 12-month reporting period from January 1 through December 31, 2009 or the six-month reporting period from July 1 through December 31, 2009. Eligible professionals (EPs) who satisfactorily report under measures groups may receive an incentive payment equivalent to 2.0% of total allowed Medicare Physician Fee Schedule (PFS) allowed charges for covered professional services furnished during the applicable reporting period.

Please note, EPs may choose to pursue more than one 2009 PQRI reporting option. Professionals who satisfactorily report under more than one reporting option will receive a maximum of one incentive payment, which will be equivalent to 2.0% of their PFS allowed charges for all covered professional services furnished, during the longest reporting period for which he or she satisfied reporting requirements. This manual describes how to implement 2009 reporting of measures groups to facilitate satisfactory reporting of quality-data by EPs who wish to participate under this reporting alternative. Additional information describing how to implement 2009 measures groups can be found in the *Getting Started with 2009 PQRI Reporting of Measures Groups* and the *PQRI Made Simple - Reporting the Preventive Care Measures Group* at: http://www.cms.hhs.gov/PQRI/30_EducationalResources.asp#TopOfPage.

EPs identify their intent to report a measures group by submitting a measures group-specific G-code on a claim for covered professional services furnished to a patient enrolled in Medicare Part B Fee-For-Service. It is not necessary to submit the measures group-specific G-code on more than one claim. If the G-code for a given group is submitted multiple times during the reporting period, only the submission with the earliest date of service will be included in the PQRI analyses; subsequent submissions of that code will be ignored. It is not necessary to submit the measures group-specific G-code for registry-based submissions.

The CABG Measures Group can only be submitted through a registry. Therefore, there is not a measures group-specific G-code.

G8485: I intend to report the Diabetes Mellitus Measures Group
G8487: I intend to report the Chronic Kidney Disease (CKD) Measures Group
G8486: I intend to report the Preventive Care Measures Group
G8490: I intend to report the Rheumatoid Arthritis Measures Group
G8492: I intend to report the Perioperative Care Measures Group
G8493: I intend to report the Back Pain Measures Group

There are two reporting methods for submission of measures groups:

Consecutive Patient Sample Method: For claims-based submissions, EPs must report on all applicable measures within the selected measures group on claims for a minimum of 30 consecutive Medicare Part B Fee-For-Service patients who meet patient sample criteria for the measures group, beginning with the first date of service for which the measures group-specific G-code is

submitted. For example, an EP can indicate intent to begin reporting the Diabetes Mellitus Measures Group by submitting G8485 on the first patient claim in the series of consecutive diabetic patients. For registry-based submissions, EPs must report on all applicable measures within the selected measures group for a minimum of 30 consecutive patients (which may include non-Medicare Part B Fee-For-Service patients) who meet patient sample criteria for the measures group. For both claims-based and registry-based submissions, all the applicable measures within the group must be reported at least once for each patient within the sample population seen during the reporting period (January 1 through December 31, 2009).

OR

80% Patient Sample Method: EPs must report on all applicable measures within the selected measures group on claims for at least 80% of all Medicare Part B Fee-For-Service patients seen during the entire reporting period (January 1 through December 31, 2009 **OR** July 1 through December 31, 2009) who meet the measures group patient sample criteria. For this method, through claims-based submissions, the measures group-specific G-code must be submitted once during the reporting period to indicate the EP's selection of the measures group. For the 12-month reporting period, a minimum of 30 patients must meet the measures group patient sample criteria to report satisfactorily. For the six-month reporting period, a minimum of 15 patients must meet the measures group patient sample criteria to report satisfactorily. All applicable measures within the group must be reported according to the individual measures group reporting instructions.

This manual contains an overview for each measures group followed by specific reporting instructions for each measure within the group.

The patient sample for both the Consecutive Patient Sample Method and the 80% Patient Sample Method are determined by diagnosis and/or encounter parameters common to all measures within a selected measures group. All applicable measures within a group must be reported for each patient within the sample that meets the criteria (age or gender) required in accordance with this manual. For example, if an EP is reporting on the Preventive Measures Group, the *Screening or Therapy for Osteoporosis* measure would only need to be reported on women within the patient sample. Denominator coding has been modified from the original measure as specified by the measure developer to allow for implementation as a measures group.

Physician Quality Reporting Initiative
Measures Groups Specifications Manual
Table of Contents

DIABETES MELLITUS MEASURES GROUP OVERVIEW

2009 PQRI MEASURES IN DIABETES MELLITUS MEASURES GROUP:

#1. Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus
#2. Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus
#3. Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus
#117. Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient
#119. Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients
#163. Diabetes Mellitus: Foot Exam

INSTRUCTIONS FOR REPORTING:

Indicate your intention to report the Diabetes Mellitus Measures Group by submitting the measures group-specific G-code on a patient claim. It is not necessary to submit the measures group-specific G-code on more than one claim. It is not necessary to submit the measures group-specific G-code for registry-based submissions.

G8485: I intend to report the Diabetes Mellitus Measures Group
Select patient sample method:
Consecutive Patient Sample Method: 30 consecutive patients meeting patient sample criteria for the measures group. For claims-based submissions, counting will begin with eligible patients seen on or after the service date indicated on the claim containing G8485.
OR
80% Patient Sample Method: All patients meeting patient sample criteria for the measure group during the entire reporting period (January 1 through December 31, 2009 **OR** July 1 through December 31, 2009). For the 12-month reporting period, a minimum of 30 patients must meet the measures group patient sample criteria to report satisfactorily. For the six-month reporting period, a minimum of 15 patients must meet the measures group patient sample criteria to report satisfactorily.

Patient sample criteria for the Diabetes Mellitus Measures Group are patients aged 18-75 years with a specific diagnosis of diabetes accompanied by a specific patient encounter:

One of the following diagnosis codes indicating diabetes: 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04

Accompanied by
One of the following patient encounter codes: 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271

Report quality-data codes on **all** measures within the Diabetes Mellitus Measures Group for the patient sample.

Instructions for quality-data code reporting for each of the measures within the Diabetes Mellitus Measures Group are displayed on the next several pages. If all quality actions for the patient have been performed for the group, the following G-code may be reported in lieu of the individual quality-data codes for each of the measures within the group.

G8494: All quality actions for the applicable measures in the Diabetes Mellitus Measures Group have been performed for this patient

To report satisfactorily of the Diabetes Mellitus Measures Group it requires **all** measures for each patient within the sample to be reported a minimum of once during the reporting period.

When using the 30 Consecutive Patient Sample Method, report each measure for the 30 consecutive patients seen. For claims-based submissions, begin with those patients meeting sample criteria on the date G8485 is submitted. When using the 80% Patient Sample Method, report each measure on at least 80% of the patient sample for the 12-month or six-month reporting period.

For claims-based submissions, the provider remittance advice will show a denial code for the claim containing G8485 as well as the claims containing quality-data codes. This denial code (N365) indicates the code is not payable and is used for reporting/informational purposes only. Other services/codes on the claim will not be affected by the addition of a measures group-specific G-code. The N365 remark code does NOT indicate whether the QDC is accurate for that claim or for the measure the EP is attempting to report.

Measure #1: Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus

DESCRIPTION:
Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent hemoglobin A1c greater than 9.0%

NUMERATOR:
Patients with most recent hemoglobin A1c level > 9.0%

Numerator Instructions: For performance, a lower rate indicates better performance/control.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Most Recent Hemoglobin A1c Level > 9.0%

CPT II 3046F: Most recent hemoglobin A1c level > 9.0%

OR

If patient is not eligible for this measure because hemoglobin A1c not performed, report:

Hemoglobin A1c not Performed

Append a reporting modifier (**8P**) to CPT Category II code **3046F** to report circumstances when the patient is not eligible for the measure.

3046F *with* 8P: Hemoglobin A1c level was not performed during the performance period (12 months)

OR

Most Recent Hemoglobin A1c Level ≤ 9.0%

CPT II 3044F: Most recent hemoglobin A1c (HbA1c) level < 7.0%

OR

CPT II 3045F: Most recent hemoglobin A1c (HbA1c) level 7.0 to 9.0%

Measure #2: Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus

DESCRIPTION:

Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent LDL-C level in control (less than 100 mg/dl)

NUMERATOR:

Patients with most recent LDL-C < 100 mg/dL

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Most Recent LDL-C Level < 100 mg/dL

CPT II 3048F: Most recent LDL-C < 100 mg/dL

OR

If patient is not eligible for this measure because LDL-C level not performed, report:

LDL-C Level not Performed

Append a reporting modifier (**8P**) to CPT Category II code **3048F** to report circumstances when the patient is not eligible for the measure.

3048F *with* 8P: LDL-C was not performed during the performance period (12 months)

OR

Most Recent LDL-C Level ≥ 100 mg/dL

CPT II 3049F: Most recent LDL-C 100-129 mg/dL

OR

CPT II 3050F: Most recent LDL-C ≥ 130 mg/dL

Measure #3: Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus

DESCRIPTION:

Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent blood pressure in control (less than 140/80 mmHg)

NUMERATOR:

Patients whose most recent blood pressure < 140/80 mmHg

Numerator Instructions: To describe both systolic and diastolic blood pressure values, two CPT II codes must be reported – 1) One to describe the systolic value; AND

2) One to describe the diastolic value. If there are multiple blood pressures on the same date of service, use the lowest systolic and lowest diastolic blood pressure on that date as the representative blood pressure.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Most Recent Blood Pressure Measurement Performed

Systolic codes **(Select one (1) code from this section):**

CPT II 3074F: Most recent systolic blood pressure < 130 mmHg

OR

CPT II 3075F: Most recent systolic blood pressure 130 - 139 mmHg

OR

CPT II 3077F: Most recent systolic blood pressure ≥ 140 mmHg

AND

Diastolic code **(Select one (1) code from this section):**

CPT II 3078F: Most recent diastolic blood pressure < 80 mmHg

OR

CPT II 3079F: Most recent diastolic blood pressure 80 - 89 mmHg

OR

CPT II 3080F: Most recent diastolic blood pressure ≥ 90 mmHg

OR

If patient is not eligible for this measure because blood pressure measurement not performed, report 2000F-8P:

Blood Pressure Measurement not Performed

Append a reporting modifier (**8P**) to CPT Category II code **2000F** to report circumstances when the patient is not eligible for the measure.

2000F *with* 8P: No documentation of blood pressure measurement

Measure #117: Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient

DESCRIPTION:

Percentage of patients aged 18 through 75 years with a diagnosis of diabetes mellitus who had a dilated eye exam

NUMERATOR:

Patients who had a dilated eye exam for diabetic retinal disease at least once within 12 months

Numerator Instructions: This includes patients with diabetes who had one of the following: A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) during the reporting period, or a negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior to the reporting period. For dilated eye exams performed 12 months prior to the reporting period, an automated result must be available.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Dilated Eye Exam Performed by an Eye Care Professional

CPT II 2022F: Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed

OR

CPT II 2024F: Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed

OR

CPT II 2026F: Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed

OR

CPT II 3072F: Low risk for retinopathy (no evidence of retinopathy in the prior year)

OR

Dilated Eye Exam not Performed, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **2022F or 2024F or 2026F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

2022F or 2024F or 2026F *with* 8P: Dilated eye exam was not performed, reason not otherwise specified

Measure #119: Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients

DESCRIPTION:

Percentage of patients aged 18 through 75 years with diabetes mellitus who received urine protein screening or medical attention for nephropathy during at least one office visit within 12 months

NUMERATOR:

Patients who have a nephropathy screening during at least one office visit within 12 months

Numerator Instructions: This measure is looking for a nephropathy screening test or evidence of nephropathy.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Nephropathy Screening Performed

CPT II 3060F: Positive microalbuminuria test result documented and reviewed

OR

CPT II 3061F: Negative microalbuminuria test result documented and reviewed

OR

CPT II 3062F: Positive macroalbuminuria test result documented and reviewed

OR

CPT II 3066F: Documentation of treatment for nephropathy (eg, patient receiving dialysis, patient being treated for ESRD, CRF, ARF, or renal insufficiency, any visit to a nephrologist)

OR

G8506: Patient receiving angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy

OR

Nephropathy Screening not Performed, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **3060F or 3061F or 3062F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3060F or 3061F or 3062F *with* 8P: Nephropathy screening was not performed, reason not otherwise specified

Measure #163: Diabetes Mellitus: Foot Exam

DESCRIPTION:

The percentage of patients aged 18 through 75 years with diabetes who had a foot examination

NUMERATOR:

Patients who received a foot exam (visual inspection, sensory exam with monofilament, or pulse exam)

Numerator Quality-Data Coding Options for Reporting Satsfactorily:

Foot Exam Performed

CPT II 2028F: Foot examination performed (includes examination through visual inspection, sensory exam with monofilament, and pulse exam – report when any of the three components are completed)

OR

Foot Exam not Performed for Medical Reason

Append a modifier (**1P**) to CPT Category II code **2028F** to report documented circumstances that appropriately exclude patients from the denominator.

2028F *with* 1P: Documentation of medical reason for not performing foot exam (i.e., patient with bilateral foot/leg amputation)

OR

Foot Exam not Performed, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **2028F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

2028F *with* 8P: Foot exam was not performed, reason not otherwise specified

When using the 30 Consecutive Patient Sample Method, report each measure for the 30 consecutive patients seen. For claims-based submissions, begin with those patients meeting sample criteria on the date G8487 is submitted. When using the 80% Patient Sample Method, report each measure on at least 80% of the patient sample for the 12-month or six-month reporting period.

For claims-based submissions, the provider remittance advice will show a denial code for the claim containing G8487 as well as the claims containing quality-data codes. This denial code (N365) indicates the code is not payable and is used for reporting/informational purposes only. Other services/codes on the claim will not be affected by the addition of a measures group-specific G-code. The N365 remark code does NOT indicate whether the QDC is accurate for that claim or for the measure the EP is attempting to report.